KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY

GUIDELINES FOR
DEEP PHYSICAL AGENT MODALITIES (DPAM)
SUPERVISOR APPLICATION PROCESS

> *The supervised treatment sessions required for DPAM Specialty Certification must be sufficiently detailed to allow the DPAM Specialty Certification Supervisor to determine the supervisee's skills. Treatment sessions shall be completed under the direct supervision of a person approved by the board. 201 KAR 28:170.*

In accordance with the Occupational Therapy Practice Act, KRS 319A.080(4), and the Administrative Regulations, 201 KAR 28:170, which provides procedures for putting the Act into practice, licensed individuals seeking DPAM Specialty Certification must demonstrate competence in DPAM application through completion of five (5) supervised treatment sessions. In order for an individual to be approved as a DPAM Specialty Certification Supervisor, the following items are required by KBLOT:

1. A completed ***DPAM Supervisor Application Form***.
2. A copy of your licensure card.

Mail to:
Kentucky Board of Licensure for Occupational Therapy
PO Box 1360
Frankfort, KY 40602

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PO Box 1360
Frankfort, KY 40602

PLEASE DO NOT FAX

DEEP PHYSICAL AGENT MODALITIES SPECIALTY CERTIFICATION (DPAM) SUPERVISOR APPLICATION

1. Supervisor Name: _____
Last *First* *Middle* *Maiden*

2. Address: _____
Mailing Address

_____ _____ _____
City *State* *Zip Code*

3. Daytime Phone: _____ - _____ Other Phone: _____ - _____

4. State Regulatory Agency Licensed or Certified by: _____

5. Address of Regulatory Agency: _____
Mailing Address

_____ _____ _____
City *State* *Zip Code*

6. License or Certification Number: _____

7.	☐ Yes ☐ No	I am currently licensed or certified by the above regulatory agency and am in good standing with the agency.
8.	☐ Yes ☐ No	I certify that I have at least one year of clinical experience in the use of DPAMs.
9.	☐ Yes ☐ No	I certify that I am qualified to determine a DPAM Specialty Certification Applicant's knowledge, skills, and competence in the following areas: (a) the ability to evaluate the client and make appropriate selection of the DPAM to be utilize, (b) knowledge of effects of the DPAM utilized in treatment, (c) the ability to explain precautions, contraindication, and rationale of the specific DPAM utilized, (d) the ability to formulate and justify the intervention plan specifically delineating the adjunctive strategy associated with the DPAM, (e) the capability to safely and appropriately administer the DPAM, and (f) the ability to properly document the parameters of intervention which include the client's response to treatment and recommendations for the progression of the intervention process.
10.	☐ Yes ☐ No	I understand that each applicant supervised must complete five treatment sessions including at least two in the following areas: (a) Ionotophoresis (b) Ultrasound, and (c) Electrical Stimulation
11.	☐ Yes ☐ No	I have attached a copy of my current professional practice license.

APPLICANT'S AFFIDAVIT

I, the applicant named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my DPAM Supervisor status could be revoked by the Kentucky Board of Licensure for Occupational Therapy.

_____ _____
Signature of DPAM Supervisor Applicant Date